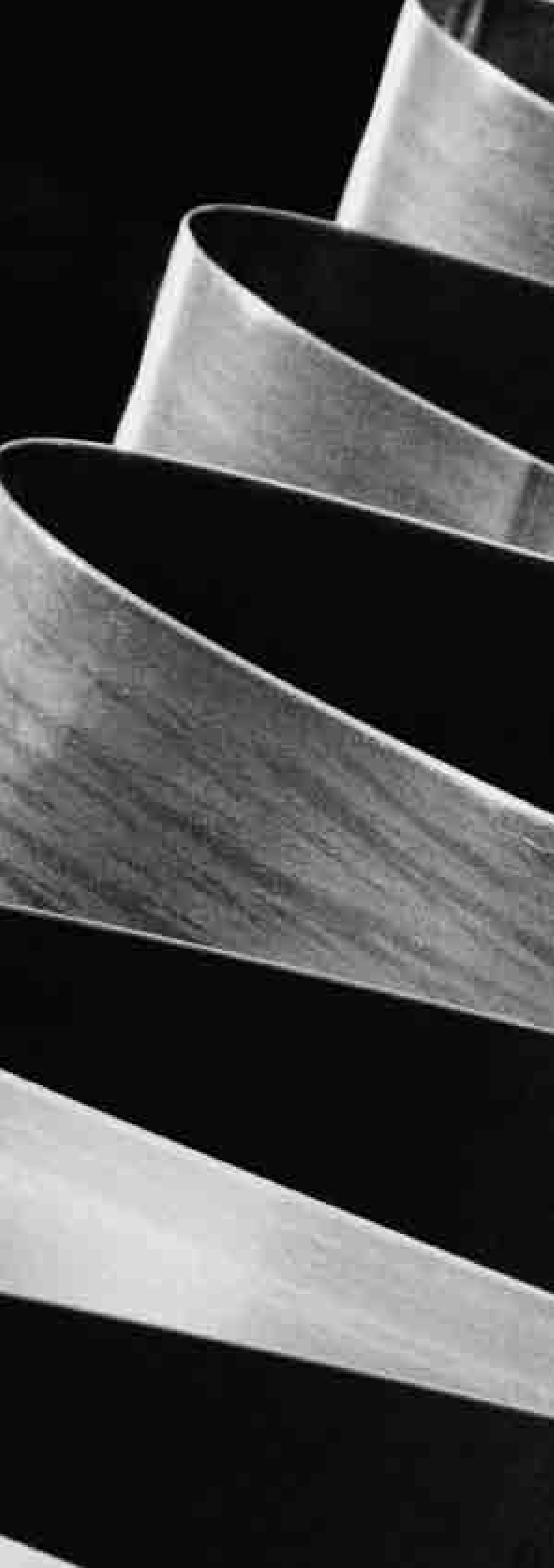


Application Form

Tele-Interviewing

Dentists' Provident

Important notes: completing this application form

Please check that you have received a Key Features Document and a Personalised Illustration, as they contain important information about the contract you wish to enter into. If you are applying to us direct, please call our Member Services Department on +44 (0) 20 7400 5710 to obtain these documents or go to www.dentistsprovident.co.uk. If you are applying through an independent financial advisor, they will be able to supply you with these documents.

If you are applying to join, the Society's Memorandum and Rules will be sent to you upon admission to membership. The Society's Memorandum and Rules, together with a copy of this application form, are also available on request.

Before answering any questions, please read them carefully and if any are unclear, please contact your independent financial advisor or our Member Services Department.

Please complete the form in **black ink**, using BLOCK CAPITALS throughout and ticking the boxes where appropriate. If you make a mistake, please cross it out, make the necessary correction next to it and initial the changes. If you need more space to write your answers, please use Section 7: additional information.

It is important that you answer all the questions (including those in the tele-interview and any supplementary questionnaires that we send to you) fully and honestly. All questions we ask are relevant and important. You must answer them accurately and completely and to the best of your knowledge and belief. If you do not, we have the right to cancel your membership and to not pay any claim. If you are in any doubt as to whether any information should be disclosed to us, then you should disclose it.

You are advised to consult your doctor and / or other professional advisors if you are not confident you will remember to disclose all current and past health and financial details that may be relevant. Your answers may be used to decide the terms on which this application is accepted without any additional information. We may not contact your doctor or your other advisors about this application. Even if we do, you should not assume we will obtain all the information we need. It remains your responsibility to complete the application form properly.

You must tell us about any changes in your health and financial circumstances that occur before the commencement of the contract. Failure to do so may result in your membership of the Society being cancelled and any claim for benefits not being paid.

The disclosures made on this application form will be treated in accordance with our confidentiality policy.

Non-smoker status

To qualify for "non-smoker" status, you must not have used any form of tobacco or nicotine products in the last 12 months. We reserve the right to check the accuracy of your reply on the application form if you have indicated that you are a "non-smoker".

Genetic testing

In line with the Association of British Insurers' Genetic Testing Code of Practice, you are not required to disclose the results of any predictive genetic tests for Income Protection Insurance at this time. You will not be asked to undergo a genetic test in connection with this application.

If you wish to disclose to us a negative genetic test result, which shows you have not inherited a genetic disorder, we will take this into account in setting your premium, providing the result is relevant, reliable and from a valid source and your clinical geneticist confirms that the test result indicates a reduced risk of developing the inherited disease.

You must tell us if you have a family history of, are experiencing symptoms of, or are having treatment for a medical condition including any genetically inherited condition.

DENTISTS' PROVIDENT

Financial advisor details

Name of company	
FSA registration number	
Full name of financial advisor	
Name of network (if applicable)	
Telephone	
Fax	
Email address	

It is an FSA requirement that we provide data as to whether advice was given on the sale of this product.

Financial advice was given in connection with the sale of this product.*
*(*please delete if no advice was given)*

Financial advisor signature	
Date	

Section 1: your personal details

1. Title	Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other (please specify) ______
2. Surname	
3. Previous surname	
4. First names	
5. Gender	Male ☐ Female ☐ — **6.** Date of birth: DD ___ MM ___ YYYY ______
7. Home address	
	8. Postcode
9. Country	
10. Home telephone	
11. Work address	
	12. Postcode
13. Country	
14. Work telephone	
15. Email address	
16. Mobile telephone	

17. What is your preferred correspondence address?	Home ☐	Work ☐
18. Are you or have you been a member of the Society?	Yes ☐	No ☐
19. Please choose the currency in which you would like to pay your premiums and receive your benefits	Pounds Sterling (£) ☐	Euros (€) ☐
20. Have you used any form of tobacco or nicotine in the last 12 months?	Yes ☐	No ☐

Please ensure you provide the information requested in the following sections in the currency you have chosen.

It is important that you answer all the questions (including those in the tele-interview and any supplementary questionnaires that we send to you) fully and honestly. All questions we ask are relevant and important. You must answer them accurately and completely and to the best of your knowledge and belief. If you do not, we have the right to cancel your membership and to not pay any claim. If you are in any doubt as to whether any information should be disclosed to us, then you should disclose it.

DENTISTS' PROVIDENT

Section 2: your employment & income

PLEASE NOTE the benefits payable on a claim may be restricted by reference to your actual pre-incapacity income, the other insurances you have and any income you continue to receive during incapacity.

1. Are you authorised to practice as a dentist in the UK or Ireland?	Yes ☐ No ☐
2. Your registration number	
3. If you are not working as a dentist, please state your occupation	
4. Are you a vocational dental practitioner / general professional trainee / house officer or foundation dentist?	Yes ☐ No ☐

If "Yes", please complete (a) and (b) below and then go to Section 4: other insurances & your income during incapacity.
If "No", please go to Question 5.

(a) The date your training contract ends	DD _____ MM _____ YYYY________________
(b) The discounted package you require	Essential ☐ Premier ☐
5. Do you have any earnings from self-employment?	Yes ☐ No ☐

If "Yes", please provide the following information for the current and previous two years.
If "No", please go to Question 6.

Your income from self-employment	Amount
Current year - Your taxable profits (your fees or contract value minus all your business expenses)	£/€ ________________
20______ - Your taxable profits (your fees or contract value minus all your business expenses)	£/€ ________________
20______ - Your taxable profits (your fees or contract value minus all your business expenses)	£/€ ________________

If there has been a material change in your profits over the last three years, or if for any reason the information requested is not available, please give full details in Section 7: additional information.

6. Do you have any earnings as an employee?	Yes ☐ No ☐

If "Yes", please provide the following information.
If "No", please go to Section 3: benefits required.

Your income from employment	Amount
Current year - Your taxable salary	£/€ ________________
Current year - Your employee bonuses	£/€ ________________
Current year - Other income in connection with this employment	£/€ ________________
Total	**£/€** ________________

Section 3: benefits required

PLEASE NOTE the benefits payable on a claim may be restricted by reference to your actual pre-incapacity income, the other insurances you have and any income you continue to receive during incapacity.

You have two main choices with regard to selecting the benefits you require:

- You can choose one or more packaged contracts by selecting the occupational category which best describes your occupational circumstances and then selecting one of the three levels of cover available within that category;
- In addition to, or as an alternative to, choosing a packaged contract, you can build one or more customised plans.

Packaged contracts: Please refer to the Key Features Document "What packages are available?" section for further information. If you have any questions about packaged contracts, please contact your independent financial advisor or our Member Services Department.

	Community Dental Services	**Dental Public Health**	**Dental Teachers Group**	**Hospital Dental Services**	**General Dental Services**
Amount of weekly sickness benefits required	£/€ ____________	£/€ ____________	£/€ ____________	£/€ ____________	£/€ ____________
	(Please tick one box)	(Please tick one box)	(Please tick one box)	(Please tick one box)	(Please tick one box)
Essential Package	☐	☐	☐	☐	☐
Classic Package	☐	☐	☐	☐	☐
Premier Package	☐	☐	☐	☐	☐
Period of time before benefit payments commence (the "Deferred Period")					None ☐ 4 weeks ☐ 13 weeks ☐ 26 weeks ☐ 52 weeks ☐ (Please tick one box as appropriate)

Customised plans: If you require more than two customised plans, please use Section 7: additional information. If you have any questions about how to customise your benefits, please contact your independent financial advisor or our Member Services Department.

Plan 1

Amount of weekly sickness benefits required	£/€ ____________
Period of time before benefit payments commence (the "Deferred Period") (Please choose between "immediately" or any number of whole weeks between 1 and 52 or 104)	
In the event of a long-term claim, would you prefer the benefits paid to you to: (Please refer to the Key Features Document "How can I customise my cover?" section for further details)	Increase in line with inflation ☐ Remain at a constant level ☐ Reduce (only available for benefits with no Deferred Period) ☐
Would you prefer the level of your cover to increase annually in line with inflation? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Escalation of Cover option)	Yes ☐ No ☐
Would you prefer to be able to increase your cover at certain times in the future by up to 30% without reapplying? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Increasable Sickness Benefit option)	Yes ☐ No ☐
In the event of a severe disability, would you prefer a long-term claim to be paid at a higher level? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Severe Disability Benefit option)	Yes ☐ No ☐
Do you require enhanced death benefits? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Enhanced Death Benefit option)	Yes ☐ No ☐

Dentists' Provident

Plan 2

Amount of weekly sickness benefits required	£/€ ______________
Period of time before benefit payments commence (the "Deferred Period") (Please choose between "immediately" or any number of whole weeks between 1 and 52 or 104)	
In the event of a long-term claim, would you prefer the benefits paid to you to: (Please refer to the Key Features Document "How can I customise my cover?" section for further details)	Increase in line with inflation ☐ Remain at a constant level ☐ Reduce (only available for benefits with no Deferred Period) ☐
Would you prefer the level of your cover to increase annually in line with inflation? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Escalation of Cover option)	Yes ☐ No ☐
Would you prefer to be able to increase your cover at certain times in the future by up to 30% without reapplying? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Increasable Sickness Benefit option)	Yes ☐ No ☐
In the event of a severe disability, would you prefer a long-term claim to be paid at a higher level? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Severe Disability Benefit option)	Yes ☐ No ☐
Do you require enhanced death benefits? (Please refer to the Key Features Document "How can I customise my cover?" section for further details on the Enhanced Death Benefit option)	Yes ☐ No ☐

If you would like to subscribe for additional plans, please use Section 7: additional information.

Shareholding

You must hold a minimum of one Share. The number of Shares you can hold depends on the level of income protection benefits you apply for. Details of how you can determine the maximum number of Shares applicable to your chosen level of benefits are set out in the Key Features Document "What is a Share?" section. If you require the maximum shareholding, please write "maximum" in the box below.

Alternatively, if you are a new member and require the minimum shareholding, or if you are an existing member and wish to retain your current shareholding, please leave the box empty.

Please state the number of Shares you require, including any Shares you hold if you are an existing member	

Section 4: other insurances & your income during incapacity

PLEASE NOTE you are advised not to cancel any existing insurance until your application has been accepted, your cover has commenced and you are satisfied that your cover from Dentists' Provident meets your requirements.

1. Do you have or are you applying for any other income protection, accident / sickness protection, mortgage protection, loan or credit card protection or waiver of premium contract(s)?	Yes ☐ No ☐

If "Yes", please provide details of the policies below. If you intend to cancel any policies on acceptance of this application, please indicate this by ticking the appropriate box.
If "No", please go to Question 2.

Name of insurer	Type of insurance	Deferred period	Weekly benefit	Policy to be cancelled?
			£/€ ________	Yes ☐ No ☐
			£/€ ________	Yes ☐ No ☐
			£/€ ________	Yes ☐ No ☐

2. Within the past five years, have you made any applications to the Society which have not resulted in membership / additional benefits?	Yes ☐ No ☐
3. Has any application, at any time, made by you for sickness, disability, accident, critical illness insurance or life assurance been postponed, withdrawn, declined, offered or accepted on special terms?	Yes ☐ No ☐

If "Yes", please provide the following information.
If "No", please go to Question 4.

Name of insurer	Type of insurance	Date	Decision & reasons

4. Has any contract of insurance held by you, at any time, been cancelled, terminated, reduced or varied by the insurer / provider by reason of misrepresentation, non-disclosure or fraud?	Yes ☐ No ☐

If "Yes", please provide the following information.
If "No", please go to Question 5.

Name of insurer	Type of insurance	Date	Decision & reasons

5. Will you receive any income from your work when you are not working due to any incapacity?	Yes ☐ No ☐

If "Yes", please provide the following information.
If "No", please go to Section 5: details of your medical practitioners.

Name of company / practice	Weekly amount	When, after the start of incapacity, will payments start?	How long will you receive these payments?
	£/€ ________		
	£/€ ________		

DENTISTS' PROVIDENT

Section 5: details of your medical practitioners

Please provide all the information requested, including postcodes and telephone numbers where appropriate. This will prevent unnecessary delays in processing your application.

1. Please provide the following details of your doctor:	
Name of your doctor	
Name of practice	
Address	
	Postcode
Country	
Telephone	
Have you been registered with this practice for more than 12 months?	Yes ☐ No ☐

If you registered with the above practice in the last 12 months, please provide the full details of your previous doctor below.
If you registered with the above practice more than 12 months ago, please go to Question 3.

2. Please provide the following details of your previous doctor:	
Name of your previous doctor	
Name of practice	
Address	
	Postcode
Country	
Telephone	

3. In the last five years, have you consulted with, been examined by or received treatment from any health professional other than those stated above?	Yes ☐ No ☐
If "Yes", please provide the following information. **If "No", please go to Section 6: how did you hear about us?**	
Name of health professional	
Specialism	
Name of practice	
Address	
	Postcode
Country	
Telephone	

If you need more space to record additional health professionals, please use Section 7: additional information.

Section 6: how did you hear about us?

☐ Financial advisor (Please give details)	
☐ Magazine (Please give details)	
☐ Trade show (Please give details)	
☐ Colleague	
☐ Other (Please give details)	

If you have no additional information to give, please sign and date the declaration on the following page. If you do have additional information to give, please write it below and then sign and date the declaration on the following page.

Section 7: additional information

Please ensure you sign and date the declaration on the following page.

DENTISTS' PROVIDENT

Declaration & consent of the applicant

This application is my offer to enter into a contract for the benefits stated in this application and, if I am not already a member, for the membership of Dentists' Provident Society Limited ("the Society"). I understand that any contract entered into will be on the Society's normal terms and conditions, which have been explained to me, and I agree to abide by the Rules and Tables of the Society present and future, for the duration of my membership of the Society.

I have received and read the Important Notes sections within this application form, the Personalised Illustration and the Key Features Document. In particular, I confirm that I understand the important exclusion clauses described within the Key Features Document. I also understand that non-standard personal underwriting terms may apply.

I understand that a copy of the Rules and a copy of this completed application are available on request.

I have read the answers to questions in this application (including those in the tele-interview and any supplementary questionnaires that have been sent to me) and declare that, to the best of my knowledge and belief, all the information given is true and no relevant fact has been misstated or withheld. I understand that failure to provide accurate and complete information may result in my membership of the Society being cancelled and that any claim for benefits may not be paid.

I acknowledge that the Society will provide me with a copy of the tele-interview report and that I will be required to read my answers to the questions in the report, correct any errors or omissions and declare that, to the best of my knowledge and belief, the information given is true and has been recorded accurately and no relevant fact has been misstated or withheld. I understand that failure to do so may result in my membership of the Society being cancelled and that any claim for benefits may not be paid.

I will inform the Society immediately of any changes that occur to any information provided in connection with this application prior to commencement of the relevant cover. I understand that failure to do so may result in my membership being cancelled and that any claim for benefits may not be paid.

I accept that, if I am required to undergo a medical examination, the results of the medical examination and / or any tests and my replies to the medical examiner's questions will form part of this application.

I acknowledge that any terms of membership which the Society may determine are made in reliance on the content of this application, the answers given in the tele-interview, any supplementary questionnaires, my medical reports, if any, and this declaration.

I have read and understood the Important Notes sections of this application, including my rights regarding access to medical reports.

I do not* wish to see any medical reports before they are sent to the Society.
(*only delete the word "not" if you wish to see the reports).

In connection with my application, I agree to the Society seeking medical information (including copies of my medical records) from any doctor who, at any time, has attended me concerning anything which affects my physical or mental health and I consent to the giving of that information.

In connection with my application, I agree to the Society seeking relevant information from other insurers about previous or concurrent applications for life, critical illness, income protection, sickness, disability, accident or private medical insurance that I have applied for and any relevant financial information (which may include my income tax returns and / or financial statements) from my accountants, financial advisors and tax authorities and I consent to the giving of that information.

I consent to the Society sharing relevant information with other insurers in connection with any concurrent applications for life, critical illness, income protection, sickness, disability, accident or private medical insurance that I have applied for.

I agree to the Society sending my authorised independent financial advisor any information regarding my application and membership, including the tele-interview report and details of any special terms applicable to my benefits.

I consent to the processing of personal data, including data such as health and medical information, by the Society and relevant third parties for the purposes of this application, membership administration, service provision, reinsurance, claims validation, and fraud detection and prevention.

I also agree that the Society, and other companies approved by it, may use the information provided to advise me of other products and services that may interest me. (If you would prefer not to receive such information, please tick this box. ☐)

I agree that a copy of the agreement given in this declaration will have the validity of the original.

Signature	
Date	
Name in full	

For use only by members with Sterling bank accounts in the United Kingdom

DENTISTS PROVIDENT

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send to:
Dentists' Provident Society, 91-94 Saffron Hill, London, EC1N 8QP.

Name and full postal address of your Bank or Building Society

To: The Manager Bank/Building Society

Address

Postcode

Name(s) of Account Holder(s)

Bank/Building Society Account Number

Branch Sort Code

Service User Number

9	9	6	6	8	4

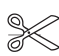
Reference

FOR DENTISTS' PROVIDENT SOCIETY OFFICIAL USE ONLY
This is not part of the instruction to your Bank or Building Society.

Instruction to your Bank or Building Society
Please pay Dentists' Provident Society Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Dentists' Provident Society and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date



Banks and Building Societies may not accept Direct Debit Instructions from some types of account.

This Guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit, Dentists' Provident Society will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Dentists' Provident Society to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by Dentists' Provident Society or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society. If you receive a refund you are not entitled to, you must pay it back when Dentists' Provident Society asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

For use only by members with Euro bank accounts in the Republic of Ireland

DENTISTS PROVIDENT

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send to:
Dentists' Provident Society, 91-94 Saffron Hill, London, EC1N 8QP.

Name and full postal address of your Bank or Building Society

To: The Manager Bank/Building Society

Address

Name(s) of Account Holder(s)

Bank/Building Society Account Number

Branch Sort Code

Service User Number

3	0	5	7	5	7

Reference

FOR DENTISTS' PROVIDENT SOCIETY OFFICIAL USE ONLY
This is not part of the instruction to your Bank or Building Society.

Instruction to your Bank or Building Society
Please pay Dentists' Provident Society Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Dentists' Provident Society and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Banks and Building Societies may not accept Direct Debit Instructions from some types of account.

This Guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit, Dentists' Provident Society will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Dentists' Provident Society to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by Dentists' Provident Society or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society. If you receive a refund you are not entitled to, you must pay it back when Dentists' Provident Society asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

DENTISTS' PROVIDENT

Important notes

Commencement of cover

Once your application has been accepted by the Society and we have a valid direct debit instruction from you or you have paid the premium due in full, then, unless you have given specific instructions to the contrary, we will commence your cover immediately and proceed with the preparation of contract documents. Please note the Society's liability does not commence until this proposal has been accepted **and** the premium due has been paid in full or we have a completed direct debit instruction. Acceptance of your application will not prejudice your right to cancel the cover in accordance with the regulatory "cooling off" provisions.

If, for any reason, the cover cannot commence immediately, we will write to you and await your agreement and / or payment before the contract commences.

It is essential that you tell us about any changes in your health and financial circumstances that occur before the commencement of cover. Failure to do so may result in your membership of the Society being cancelled and any claim for benefits not being paid.

You should keep a record of all the information supplied to us in connection with entering into this contract (including copies of letters, supplementary questionnaires and tele-interview reports).

Access to Medical Reports Act 1988

We may need to obtain medical reports to support your application. Before we can apply for a medical report from any doctor that you have consulted, we need your permission under the Access to Medical Reports Act 1988 / Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 / Access to Health Records and Reports Act 1993 (Isle of Man). Your rights under the Act are as follows:

- You do not need to give your permission, but if you do not, we may not be able to proceed with your application. This does not prevent you from applying to other companies for insurance.
- You can ask to see the report before the doctor sends it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can make arrangements to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- You can consent to the application for the report and indicate that you do not wish to see the report before it is supplied. If you change your mind after the application is made and tell the doctor in writing, they will allow 21 days to elapse after such a notification so that you may arrange to see the report (if the report has not already been supplied before you change your mind). Whether or not you decide to see the report before it is sent, you have the right to ask your doctor for a copy of the report at any time up to six months after it was supplied, but they are entitled to make a charge for this.
- If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to any part of the report if, for example, they feel it would cause serious physical or mental harm to you or others or would indicate their intentions towards you.

We have a confidentiality policy, which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

We may ask you to contact your doctor to expedite the completion of any reports we have asked for.

If you have any questions about your rights under the Act or questions relating to the process of obtaining, assessing or storing medical information, please write to: Head of Compliance, Dentists' Provident Society Limited, 91-94 Saffron Hill, London, United Kingdom, EC1N 8QP.

Data Protection Act 1998 - Use of your information

For the purpose of the Data Protection Act 1998, the data controller in relation to the information you supply is Dentists' Provident Society Limited.

Any information you give to us will be held in accordance with the Data Protection Act 1998. It will be used to process your application and claims and to administer your membership. We may use it, as appropriate, to detect and prevent fraud or improper claims or for statistical analysis to help us assess how the membership of the Society is used.

We, or agents authorised by us, reserve the right to discuss the relevant aspects of your medical treatment or examination with the provider of that treatment or examination.

We may need to send your information, including your health and financial information, to relevant third parties. We may also need to send them details at a later stage for purposes relating to the management of your membership.

As a data subject, you have the right under the Act to ask your data controller for a copy of personal data you have supplied and to ask for inaccurate data to be corrected. All personal information supplied by you will be treated in confidence by the Society and will not be disclosed to any third parties, except where your consent has been received or where permitted by Law.

Dentists' Provident Society Limited

Registered office:
91-94 Saffron Hill
London
England
EC1N 8QP

Telephone number: **+44 (0) 20 7400 5700**
We may monitor calls to improve our service.

Fax number: **+44 (0) 20 7400 5701**
Website: **www.dentistsprovident.co.uk**

Dentists' Provident is the trading name of Dentists' Provident Society Limited which is incorporated in the United Kingdom under the Friendly Societies Act 1992 (Registration Number 407F) and is authorised and regulated by the Financial Services Authority (Firm Reference Number 110015)

06/11